AFFIDAVIT OF CERTIFICATION
Financial Management Services Fiscal/Employer Agent

A MATERIAL OR FALSE STATEMENT OR OMISSION MADE IN CONNECTION WITH THIS APPLICATION IS SUFFICIENT CAUSE FOR DENIAL OF CERTIFICATION, OR DECERTIFICATION, AND MAY SUBJECT THE PERSON AND/OR ENTITY MAKING THE FALSE STATEMENT TO ANY AND ALL CIVIL AND CRIMINAL PENALTIES AVAILABLE PURSUANT TO APPLICABLE FEDERAL AND STATE LAW.

I _____ (full name printed), swear under penalty of law that

I am _____ (title) of applicant agency _____ (agency name) and that I have read and understand all of the questions in this application and that all of the information and statements submitted in this application and its attachments and supporting documents are true and correct to the best of my knowledge, and that all responses to the questions are full and complete, omitting no material information. The responses include all material information necessary to fully and accurately identify and explain the operations, capabilities and pertinent history of the named agency as well as the ownership, control, and affiliations thereof.

I recognize that the information submitted in this application is for the purpose of obtaining certification as a Financial Management Services (FMS) Fiscal/Employer Agent (F/EA) for participants in the state's Self-Directed Services program by the California Department of Developmental Services (hereinafter referred to as "DDS"). I understand that DDS may, by means it deems appropriate, determine the accuracy and truth of the statements in the application, and I authorize such agency to contact any entity named in the application, and the named agency's bonding companies, banking institutions, credit agencies, contractors, clients, and other certifying agencies for the purpose of verifying the information supplied and determining the named agency's eligibility. I also understand that the certification requirements for a FMS provider may be subject to change in the future.

If issued a letter of certification, I agree to promptly and directly provide DDS, the California Department of Health Care Services (the state Medicaid agency), or the Centers for Medicare & Medicaid Services (the federal funding agency), as needed or as requested, current, complete and accurate information regarding participants, accounting records, and proposed changes, if any, to the foregoing arrangements**. I understand that the issuance of a letter of certification does not guarantee that I will be vendored by a regional center or utilized by any participant.**

I agree to submit to all audits conducted by DDS or the regional center, examination and review of books, records, documents and files, in whatever form they exist, of the named agency and its affiliates, inspection of its places(s) of business and equipment, and to permit interviews of its principals, agents, and employees. I understand that refusal to permit such inquiries shall be grounds for denial or revocation of certification.

I agree to provide written notice to DDS of any material change in the information contained in the original application within 30 calendar days of such change (e.g., ownership, address, telephone number, etc.).

Signature on page 2 of 2

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Financial Management Services Fiscal/Employer Agent

I acknowledge and agree that any misrepresentations in this application or any associated documents will be grounds for denial or revocation of certification and for initiating action under federal and/or state law concerning false statement, fraud or other applicable offenses.

I acknowledge that DDS reserves the right to do a readiness review to verify the accuracy of representations made by the applicant.

I certify that my doing business as an FMS F/EA does not constitute a conflict of interest. I further certify that I am an executive director or other person serving in like capacity of the named agency seeking certification as an FMS F/EA.

I declare under penalty of law that the information provided in this application and supporting documents is true and correct.

Executed on _____ (Date) Signature _____ (Applicant)	NOTARY CERTIFICATE: